



eMediateINFUSIONcenter

BENLYSTA(belumumab)

- New Prescription/Referral
- Prescription Refill

of Refills:

Rx:

Patient Name:

DOB:

BENLYSTA:

- Initial: 10 mg/kg IV q2Weeks x 3 doses, THEN
- Maintenance: 10 mg/kg IV q4Weeks

- 400-mg dose (two 200-mg injections) SC qWeek x 4 doses, THEN
- 200 mg SC qWeek

Other Orders:

Pre-Medication: (30 mins prior)

- Solumedrol 125mg IVP
- Solu-Cortef 100mg IVP
- Others:

- Tylenol _____ mg PO
- 650mg 975mg

- Benadryl _____ mg
- 25mg IV
- 50mg PO

ANA Kit Protocol:

- OK to use

Dx:

- Systemic Lupus Erythematosus (M32.9)
- Others:

Physician Signature

NPI#:

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information: Phone:

Fax:

Email:

Other:

Office Mailing Address:

- Please include the following**
- Patient demographics
 - Lab Results
 - Insurance attached
 - Clinical progress notes
 - Diagnosis (supporting)
 - Medication List
 - History and Physical
 - Other Test Results

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